

SPIRE HEALTHCARE

COMPETITION COMMISSION

PRIVATE HEALTHCARE MARKET INVESTIGATION

**RESPONSE TO THE PROVISIONAL DECISION ON REMEDIES -
REMITTAL**

13 APRIL 2016

SPIRE'S RESPONSE TO THE PROVISIONAL DECISION ON REMEDIES (*PDR*)

1. INTRODUCTION & EXECUTIVE SUMMARY

1.1 This document provides the response (the *Response*) of Spire Healthcare (*Spire*) to the Provisional decision on remedies (*PDR*) issued on 22 March 2016 by the Competition and Markets Authority (*CMA*) in the context of the private healthcare market investigation remittal.

1.2 Spire is disappointed with the CMA's provisional decision not to impose any remedy to address the adverse effect on competition (*AEC*) of structural features in the markets for the provision of privately funded healthcare services to insured patients in central London which the CMA has confirmed in its Provisional Findings (*PFs*). Spire considers that the failure to order the proposed divestiture package (along with other complementary remedies) is a missed opportunity to bolster competition in the London market for insured patients and is inconsistent with the CMA's duty under the Enterprise Act to remedy adverse effects on competition.

1.3 The CMA's decision not to impose any remedy is largely predicated on the finding that "*large scale entry seems likely to take place by early 2020*".¹ In fact, it is predicated on the CMA's belief that one particular greenfield provider, the Cleveland Clinic, is likely to enter the market with a new hospital by 2020. The CMA indicates in its provisional decision on remedies that it does "*not attach significant weight to the prospect of entry by others, given the greater uncertainty over their entry or, in some cases, the more limited range of services likely to be provided by them.*"² In the CMA's view this entry would fully address the AEC it has identified in its PFs in relation to the London market for insured patients. However, there is still considerable uncertainty as to whether entry will occur (and if so in what timescale) and it seems excessively optimistic to assume that such entry will be able to remove that AEC entirely. This is particularly the case since the CMA has failed to consider one of the barriers to entry by the Cleveland Clinic identified by PMIs (and other prospective entrants to central London, including Spire).

1.4 The CMA has failed to give proper (or, apparently, any) consideration to one of the features which hampers competition and entry/expansion in the market, and which contributes to the AEC identified by the CMA, namely the existence of clauses in contracts between insurers and HCA which restrict the ability of insurers to refer patients to competing hospitals (*Restrictive Clauses*) and thereby limit the ability and incentives of existing competitors to compete, making new entrants a less effective constraint over HCA (and further entry less attractive).

1.5 In order to maximise the scope for competition to flourish, the CMA should prohibit Restrictive Clauses. By doing so, the scenario of entry envisaged by the CMA would be far more likely to occur, and to be effective in addressing the identified AEC. Also, until that entry materialises, a ban on Restrictive Clauses

¹ PDR, para. 1.85.

² PDR, para 11.

would help mitigate the effects of the AEC, spurring effective competition between existing competitors and increasing the likelihood of entry by other operators.

2. THE CMA HAS FAILED TO ADDRESS THE AEC IDENTIFIED

2.1 In the PFs, the CMA provisionally concluded that two structural features in the market for the provision of privately-funded healthcare services to insured patients in central London are, in combination, leading to an AEC: (i) high concentration, with HCA having a large market share; and (ii) high barriers to entry and expansion, arising primarily from high sunk costs and long lead times, the latter being exacerbated by limited site availability and planning constraints (*Insured AEC*).³ According to the CMA, these features result in weak competitive constraints on HCA in the insured patients market in central London, leading to customer detriment in the form of higher prices being charged by HCA.⁴

2.2 However, in the present case, despite the finding of an AEC with such wide reaching impact on the market (and the ample evidence that HCA enjoys market power)⁵, the CMA has surprisingly concluded that no remedies are necessary to tackle that AEC. The CMA believes that entry of the Cleveland Clinic into the market is likely and that, in combination with existing competition, it will impose an effective constraint over HCA by 2022.⁶ On this basis, the CMA concludes that “*there are no remedies that would be both effective and proportionate in addressing the features that we have identified*”.⁷

2.3 This decision is entirely unreasonable for three reasons:

- (a) The PDR places undue weight on the possible entry of Cleveland Clinic to fully address the Insured AEC;
- (b) The PDR unjustifiably dismisses the need to consider remedies to mitigate the effects of that AEC until entry is able to constrain HCA; and
- (c) The PDR fails to take into account a relevant consideration, notably the evidence presented to the CMA which strongly suggests that the ability of both the Cleveland Clinic and existing non-HCA private hospitals to compete with HCA will be restricted by the Restrictive Clauses.

Undue weight on entry

2.4 If the CMA concludes that there is an AEC, under section 138 of the Enterprise Act (*EA*), the CMA is under a duty to remedy, mitigate or prevent that AEC, apart from in exceptional circumstances, i.e., when there is no detriment to

³ PFs, para. 4.

⁴ PFs, paras. 5 and 6.

⁵ PFs, para. 30.

⁶ PDR, para. 1.85.

⁷ PDR, para. 3.7.

customers arising from the AEC and the AEC is not being remedied, mitigated or prevented.⁸ Neither exception applies in the present case.

2.5 In its Guidelines for Market Investigations, the CMA indicates that the prospect of entry or expansion “*may sometimes offset competitive harm that may otherwise arise*” if “*actual entry or expansion is likely, of sufficient scale and swift enough to constrain incumbent firms in the near future.*”⁹ This approach is consistent with the CMA’s approach to assessing the threat of entry or expansion in other situations, for example, in reviewing mergers.

2.6 There is considerable uncertainty as to the extent to which the large scale entry envisaged by the CMA meets the requirements outlined in the Guidelines for Market Investigations. In particular:

- (a) **Effective entry is not likely:** one major condition for entry is outstanding, as the Cleveland Clinic has yet to secure planning approval for the new planned facility. Despite the Cleveland Clinic’s best efforts, there is a real chance that the approval will be denied or that conditions attached to it will make the project uneconomical. The CMA, in fact, found that planning regulations constituted a barrier to entry in central London, although it did note that these are most acute where use swaps are required.¹⁰ Moreover, as explained below, entry will not be effective because of the Restrictive Clauses, as competing hospitals will be severely hindered in their ability to attract new patients.
- (b) **Effective entry is not of sufficient scale:** despite the size of the hospital the Cleveland Clinic is planning to open, it is only one facility and it will not offer all specialties. In particular the Cleveland Clinic does not plan to offer oncology, which is one of the specialities in which HCA has the strongest market position in central London (over 60%).¹¹ As a result, the anticipated entry will make no contribution to addressing the AEC in relation to oncology services in central London (which according to the CMA constitutes a separate relevant market).¹² Contrary to the CMA’s assertions, given that the development of a radiotherapy site requires the installation of bunkers into the building to house the radiotherapy equipment, it cannot be assumed that a hospital without such infrastructure can be adapted to include a radiotherapy bunker (at the very least it would be very costly and highly disruptive to the operation of the hospital).

⁸ EA, Section 138 (2) and (6).

⁹ Guidelines for Market Investigations, para 175.

¹⁰ Provisional Findings, para. 5.57.

¹¹ Final Report, para. 6.208.

¹² Final Report, paras. 5.53 and 5.70.

- (c) **Effective entry is not swift enough:** entry can hardly be considered “swift” if it will only become an effective constraint in six years. Moreover, the CMA recognises that there could be delays in obtaining the planning permission or in converting the site.¹³ The pre-planning process in London can be arduous and planning is rarely straightforward. It is also probable that after the hospital opens it will take longer than the CMA anticipates for the Cleveland Clinic (or any new entrant) to become an effective competitor able to constrain HCA, in particular because consultants practising in London are resistant to change their practice patterns (given HCA’s ties to primary care facilities, loyalty to HCA and also as a result of the Restrictive Clauses, as detailed below). This means that the Insured AEC and the corresponding customer detriment may remain for a longer period than the CMA has anticipated.

Failure to take measures to mitigate the effects of the Insured AEC

2.7 Even if the CMA could legitimately conclude that entry by the Cleveland Clinic would fully address the Insured AEC, the CMA would still be under a duty to consider measures to mitigate the effects of that AEC until such time as the new entrant is sufficiently established and can adequately constrain HCA. By allowing the Restrictive Clauses to remain in place, the CMA has failed to adequately discharge its duty to mitigate the effects of the AEC.

Failure to consider the evidence of negative impact of the Restricted Clauses

2.8 First, the CMA has ***inexplicably chosen to ignore relevant evidence*** submitted by both Spire and Bupa in relation to the existence of Restrictive Clauses and their impact on competition in the insured market in central London.

2.9 [REDACTED]

2.10 In its response to the NPR Bupa explained in detail the negative effects of these clauses. In particular, Bupa raised the following concerns:

- (a) HCA’s strong market position means that it is able to negotiate contractual clauses into agreements with insurers that protect its existing patient flows, restricting the insurer’s ability to guide volume away from HCA (i.e., restricting the ability of insurers to refer patients to competing cheaper hospitals) or to launch new products and networks without HCA.¹⁴

¹³ PDR, para. 1.64.

¹⁴ Bupa’s Response to the NPR, para. 2.41 (ii).

- (b) The effect of these clauses is to protect HCA from competition from existing competitors, restrict choice of insurance products and make entry more difficult.¹⁵
- (c) There is no guarantee that insurers will be able to negotiate these clauses out of future contracts fairly or without exchanging other significant concessions.¹⁶ This is due to HCA’s market power and the ‘must have’ status of its hospitals,¹⁷ which give HCA a very strong negotiating position.¹⁸
- (d) HCA may have similar clauses in its contracts with other insurers, which would compound the difficulty of existing competitors and new entrants to gain sufficient insurer business.¹⁹

2.11 As a result, Bupa proposed that, together with the divestiture remedy, the CMA should impose a behavioural remedy whereby HCA would have to remove those Restrictive Clauses from contracts with insurers, to ensure the success of the newly-divested facilities.²⁰

2.12 The concerns identified by Spire and by Bupa correspond to previous findings by the CMA, and to other evidence before the CMA, which do not appear to have been properly considered in the PDR. In particular:

- (a) [REDACTED]
- (b) [REDACTED]²¹ [REDACTED]²² [REDACTED]
- (c) The CMA has also recognised the significant effect that a lack of PMI recognition could have on a new entrant. In its April 2014 final report in the Private Healthcare MIR, while it did not find that PMI recognition was a barrier to entry, the CMA noted the importance of PMI recognition to entry: *“Clearly, because of their size, and also the effect of ‘consultant drag’, if one or both of the largest PMIs were to decline to recognize a potential new entrant it would make it difficult*

¹⁵ Bupa’s Response to the NPR, paras. 2.7 (iii) and 4.4.

¹⁶ Bupa’s Response to the NPR, para. 2.41 (ii). The CMA also acknowledges in the PFs that PMIs do not have countervailing bargaining power over HCA (paras. 30, 6.76 and 6.78).

¹⁷ Both Bupa and Axa consider that HCA’s hospitals are a ‘must have’ (PFs, paras. 6.21 and 6.22).

¹⁸ The CMA’s view (para. 24 of the NPR) that “[t]he combination of a specialty-level product market, and prices that are negotiated jointly across a full range of services, suggested that a strong market position in one or a small number of specialities would allow a private hospital operator to exert market power” is confirmed by Bupa’s submission (para. 2.7 of Bupa’s Response to the NPR).

¹⁹ Bupa’s response to the NPR, para. 3.20 (iv).

²⁰ Bupa’s Response to the NPR, para. 1.25.

²¹ [REDACTED]

²² See: Spire letter to the CMA of 29 May 2013.

*for it to enter a local market successfully.*²³ To the extent that HCA has been able to use its market power in central London to introduce and/or maintain Restrictive Clauses into its agreements with PMIs, those restrictions on referrals could make it very difficult for the new operator to succeed in central London.

- (d) There is a real risk that any Restrictive Clauses could limit the ability of a new entrant to attract referrals from both clinicians and PMIs. [X] As the CMA noted in its Final Report, a lack of PMI recognition or limitations on PMI referrals have a material impact on the ability of a provider to attract and retain consultants. When combined with other concerns of consultants about new providers in central London, any clauses in existing contracts between private hospitals and PMIs that limit referrals to new facilities in central London could have a very significant impact on the competitive viability of a new hospital.

2.13 The CMA has acknowledged that HCA has market power and that PMIs have a limited ability to counter that power in the context of contract negotiations, as their own customers consider HCA's hospitals to be a 'must have'.²⁴ In light of these facts and the importance of insured patients for new entrants (in particular of Bupa and Axa),²⁵ the CMA could not have ignored that Restrictive Clauses imposed by HCA contribute to the Insured AEC (by reinforcing the barriers to entry).

2.14 Despite these findings and repeated submissions from several parties, the CMA has completely ignored this body of evidence and has failed to carry out any assessment of the effects of these Restrictive Clauses. This fundamental gap in the CMA's analysis renders the conclusions drawn in the PDR manifestly unreasoned and unsubstantiated.

2.15 Second, *the CMA's conclusions are unreasonable* on the face of the facts and of the evidence submitted during the process.

2.16 Irrespective of the fact that the CMA considers that the divestiture remedy is no longer necessary, the restrictions imposed by Restrictive Clauses will continue to affect adversely the ability of existing competitors and new entrants to compete for insured patients in central London. Through these clauses, even if competing hospitals are able to offer better prices and better quality services, they would still have undue difficulty attracting more insured patients and winning new business. Similarly, insurers and other customers cannot take full advantage of the services offered by competing hospitals (including the Cleveland Clinic in the future). As a

²³ Final Report, para 6.117.

²⁴ PFs, paras. 28-30, 6.76 and 6.78. The CMA concluded that PMIs are not able to negotiate on a 'take-it-or-leave-it' basis with HCA (PFs, para. 6.77). The CMA has also found that, as a result of this 'must have' status of HCA's hospitals, PMIs have limited outside options. Indeed, there is a limited uptake in open referral policies (and HCA still receives a sizeable proportion of open referrals) and in restricted network policies excluding HCA (PFs, paras. 6.70 and 6.77).

²⁵ PFs, para. 6.43.

result, competing hospitals and new entrants will not succeed in effectively constraining HCA as long as those Restrictive Clauses are still in place.

2.17 It is generally accepted that this type of restriction is particularly harmful to competition when “*competitors [are] not able to compete for an individual customer's entire demand because the dominant undertaking is an unavoidable trading partner at least for part of the demand on the market, for instance because its brand is a ‘must stock item’ preferred by many final consumers.*”²⁶ This is clearly the case in the relevant market, as the CMA has previously acknowledged.

2.18 Furthermore, these clauses risk completely undermining the effectiveness of new entry or, at least, severely delaying the ability of the new entrant to become a competitive constraint over HCA. It is not plausible or credible to conclude that entry would succeed when contractual clauses restrict the ability of PMIs to refer patients to the new hospital. This circumstance makes the CMA’s conclusion that new entry will create sufficient competitive constraints on HCA from 2022 (and, in particular, the CMA’s assertion that a new entrant could have an impact ahead of opening) entirely untenable.²⁷ In fact, as noted above, it would be contradictory for the CMA to reach a finding of an AEC on the basis of high barriers to entry but then allow contractual clauses which clearly reinforce those barriers to remain in place.

2.19 The effect of these clauses is particularly harmful in relation to oncology services where competition is severely limited and will continue to be so after the Cleveland Clinic hospital opens (as the new facility will not provide oncology or radiotherapy). Barriers to entry and expansion in the oncology market in central London are especially high [§<]. In particular:

- (a) There is limited site availability in London and the development of a radiotherapy site requires the installation of bunkers into the building to house the radiotherapy equipment (a site that is suitable for a hospital may not be able to accommodate a radiotherapy facility);
- (b) Securing planning approval is more difficult and burdensome;
- (c) The density of buildings in London materially increases the complexity of delivering building projects; and
- (d) The loyalty of consultants to HCA makes it very challenging for competitors to attract consultants to non-HCA hospitals (which in turn makes it more difficult to attract clinical staff as well). This loyalty is due to HCA’s strong reputation, leading market position and the doctors’ ownership interests in HCA’s oncology subsidiary Leaders in Oncology Care (**LOC**). Even a 5% ownership stake in LOC (in line

²⁶ Communication from the European Commission – Guidance on the Commission's enforcement priorities in applying Article [102] of the [TFEU] to abusive exclusionary conduct by dominant undertakings, para. 36.

²⁷ PDR, para. 1.82.

with the restriction imposed by the Order) represents a significant financial return given the size of the business, thus ensuring loyalty.²⁸

2.20 Moreover, it cannot be argued that the Private Healthcare Market Investigation Order 2014 (*Order*) is capable of addressing the distortive effects of the Restrictive Clauses. The Order's scope is limited to restrictions imposed on or incentives given to consultants for referrals and, as such, it does not cover distortions of referral decisions through limitations in PMI contracts. In addition, the Order is not suited to tackle distortions in the consultants' decisions as to whether or not to practice in non-HCA hospitals caused by those clauses. Due to those restrictions in PMI contracts, consultants practicing at non-HCA hospitals face the risk of reduced referrals. This risk acts as a strong obstacle for competitors to attract consultants away from HCA.

2.21 As a result, the PDR's reasoning is manifestly flawed. By ignoring, or failing to give sufficient weight to, the impact of Restrictive Clauses on the ability of non-HCA London hospitals to compete with HCA, the CMA has failed to give due consideration to a material fact. Had the CMA adequately investigated the effect of these clauses, it could only have concluded that large scale entry is unlikely to constitute a sufficient constraint over HCA in the medium term while these Restrictive Clauses remain in force (in fact, given the manifest anti-competitive effect of the Restrictive Clauses, it would probably not be open to the CMA to reach the conclusion that the anticipated entry would be sufficient to constrain HCA). Consequently, the CMA has failed to meet the requisite legal standard to decide not to impose any measures to remedy, mitigate or prevent the AEC it has identified.

3. PROPOSED ALTERNATIVE REMEDY: BAN ON CLAUSES RESTRICTING THE PMI'S ABILITY TO REFER PATIENTS TO NON-HCA HOSPITALS

3.1 Having established the negative effect of Restrictive Clauses on competition and that the anticipated new entry is unlikely to curtail those effects (and may in fact be deterred or significantly delayed), it follows that the Insured AEC will not be fully addressed by the potential entry by the Cleveland Clinic. Consequently, it is necessary to consider how to remedy the Insured AEC or, at least, consider measures to mitigate its effects until the anticipated new entry is able to exert sufficient competitive constraint over HCA and make sure that entry – if it happens at all – stands a better chance of success.

Aim of the remedy

3.2 The aim of the remedy is to create conditions for more intense competition in the market for insured patients in central London, by removing barriers to insurers to refer patients to non-HCA hospitals. This remedy will also promote new entry insofar as it will make a wider group of customers contestable to new entrants.

Proposed remedy design

²⁸ For additional detail, see Spire's response to the CMA's request for information dated 29 March 2016.

3.3 The remedy could involve an order addressed to HCA (or to all providers in central London) prohibiting Restrictive Clauses with anti-circumvention provisions. Such an order could to a significant extent be modelled on Part 3 of the Order, which addresses arrangements between private healthcare providers and consultants.

3.4 A remedy prohibiting Restrictive Clauses must be sufficiently wide to ensure that the restrictions could not be circumvented by HCA. This should include, at a minimum, a ban on HCA and insurers and other funders of private healthcare from entering into any arrangement (in respect of all inpatient, day-case or outpatient London facilities which HCA operates or has ownership interests in):

- (a) restricting any insurer or other customer from directing referrals away from HCA for any reason;
- (b) imposing financial penalties or disincentives on insurers or other customers based on volume or revenues generated with HCA; and
- (c) granting financial incentives to maintain or increase volumes or revenues generated with HCA.

3.5 The order should mandate HCA and insurers to remove all Restrictive Clauses from their contracts immediately after the order enters into force and clarify that, in the meantime, those clauses are unenforceable.

3.6 Spire does not consider that new entry will remove the negative effects of the Restrictive Clauses and, as a result, the proposed remedy should not be time limited. However, if the CMA maintains its conclusion that entry by the Cleveland Clinic could fully address the Insured AEC, the prohibition of Restrictive Clauses would still be necessary but could be subject to a sunset clause, in order to mitigate the negative effects of the Restrictive Clauses until such time as the new entrant is able to adequately constrain HCA. The prohibition should remain in place for at least ten years after the order enters into force.

Remedy will be effective (practicable and timely)

3.7 A ban on Restrictive Clauses would be effective in addressing the Insured AEC, or at least in mitigating its effects until new entry can constrain HCA, for four reasons:

- (a) First, the remedy would allow ***existing competitors*** to access a part of demand which was effectively not available to them. Removing those restrictions would give flexibility for more patients to choose other providers and therefore will increase the ability and incentive of non-HCA hospitals to compete with HCA. As a result, this measure would be effective to reduce HCA's high market shares in the central London market, thereby mitigating the AEC.
- (b) Second, the ban of Restrictive Clauses would also support ***new entrants*** into the central London market and will make new entry more effective in constraining HCA. This remedy would also give other

potential new entrants additional confidence that their facilities will be able to compete on equal footing with HCA. [X];

- (c) Third, through the proposed remedy, *insurers* would no longer be constrained in their referral decisions, further reducing distortions of referral decisions and increasing *patient* choice of diagnosis and treatment options; and
- (d) Fourth, removing those clauses would help give *consultants* confidence that practicing at non-HCA London hospitals would not result in a decrease in their referrals due to the Restrictive Clauses. Spire notes the CMA's assertion that the Order limits HCA from preventing competitors from attracting and retaining consultants²⁹. However, the Order does not address consultants' unwillingness to practice at non-HCA competitors due to concerns that HCA would retain referrals due to Restrictive Clauses. Removing those clauses would allow non-HCA hospitals to strengthen their competitive position by removing this barrier to consultant mobility.

3.8 The remedy would be capable of immediate implementation as contractual amendments could be negotiated in very short. It would also have instantaneous effect, given that Restrictive Clauses would be unenforceable by HCA from the moment the order enters into force, thus enabling PMIs to immediately start referring patients to other hospitals.

Remedy will be proportionate

3.9 As discussed above, the proposed ban on Restrictive Clauses would be effective to deal with the causes of the Insured AEC, namely HCA's high market shares and barriers to entry in the central London market. Even if the CMA considers that entry will fully address the Insured AEC, the proposed remedy would at least be effective to mitigate the effects of the AEC until new entry becomes an adequate constraint on HCA.

3.10 In terms of the *cost/benefit balance* of the remedy, the benefits clearly outweigh the costs and the remedy is not more onerous than necessary to achieve its aim. The ban would yield significant benefits by spurring competition from existing competitors, making entry more attractive and increasing choice for patients. The proposed ban could be implemented at minimal cost, by way of contractual amendments. The remedy would not remove any existing relevant customer benefits (RCBs), as the Restrictive Clauses have no obvious economic benefit and are clearly not pro-competitive (quite the contrary, in fact). The ban could have an impact on HCA's profitability and patient numbers, but these impacts cannot be considered as implementation costs of the remedy, but merely evidence of the remedy being successful in its aim.

²⁹ Paragraph 1.76 of the PDR

3.11 The remedy would not require any *monitoring* resources to ensure compliance. It would be in the insurers' interests to ensure the ban is strictly complied with, as they would have the chance to obtain better terms from competing hospitals and also from HCA (as their bargaining power vis-à-vis HCA would increase and they could obtain better terms by threatening to refer patients to other hospitals). Since the prohibition applies to both insurers and HCA and insurers would also be liable for any breach, they would have a strong incentive to ensure that those clauses are removed from the contracts with HCA as quickly as possible. In any event, insurers would not need HCA's cooperation to make the ban effective, since those Restrictive Clauses would be unenforceable from the moment the order entered into force.

3.12 Finally, given the benefits arising from removing this barrier to other providers competing with HCA and the minimal cost of implementation, no other remedy would be less onerous to effectively achieve the aim of the remedy. Any alternative scenario in which such clauses were allowed to continue in force would jeopardise significant gains from competition.

3.13 Even if the CMA considers that entry by the Cleveland Clinic (together with other non-HCA facilities) can provide sufficient competitive constraint on HCA in the medium term, allowing these clauses to persist would significantly delay the new market balance and preclude customers from reaping the gains from added competition until much later. Indeed, these clauses entrench HCA's market position and 'must have' status, making it more difficult for a new entrant to establish itself and to effectively constrain HCA.

Remedy will not give rise to unintended adverse consequences

3.14 Spire cannot anticipate any adverse consequences from the proposed remedy, as it simply re-aligns insurer's incentives when making referral decisions, allowing the process of competition to determine that choice. The concerns raised in relation to the tying/bundling remedy do not arise in relation to the proposed ban on Restrictive Clauses, since the ban will not interfere with HCA's and insurers' pricing.

4. CONCLUSION

4.1 In summary, if the CMA concludes in its final report that structural features in the markets for the provision of privately funded healthcare services to insured patients in central London are leading to an AEC and weak competitive constraints on HCA, the CMA has a duty under the Enterprise Act to remedy, mitigate or prevent that AEC. The CMA cannot rely on an assumption that over the next four to six years the Cleveland Clinic, a greenfield operator with no existing business in the UK, will overcome all other barriers to entry identified by the CMA and emerge as an effective competitor to HCA as a basis to set aside that duty.

4.2 In particular, the CMA cannot assume that this entry will occur and will be effective when it has failed to consider a specific barrier to successful entry in central London identified by both customers of, and competitors to, HCA. The CMA has failed to take into due consideration the evidence pointing towards the negative effects of Restrictive Clauses on competition in the central London market. These

clauses significantly contribute to the Insured AEC insofar as they effectively insulate HCA from competition from existing providers and new entrants. These clauses pose a material risk to the success of any new entry, including that by the Cleveland Clinic.

4.3 As a result, the CMA should have considered appropriate measures to remedy this aspect of the Insured AEC or at least to mitigate its effects until new entry is able to sufficiently constrain HCA. Spire submits that the CMA should prohibit Restrictive Clauses in contracts between HCA (and other operators in central London) and insurers as that would be the most effective and proportionate remedy to tackle the obstructive effects of those clauses, to promote effective competition on the market and to ensure that the anticipated entry by the Cleveland Clinic – or indeed Spire – is possible and effective.